AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

September 02, 2014

Quick Links

MA-ACA Website

These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

Grant Activity

For information about ACA grants awarded to and grant proposals submitted by the Commonwealth, visit the Grants page of the **Massachusetts National Health Care Reform website** at: www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/national-health-care-reform-plan/grants-and-demonstrations.html

Guidance

8/26/14 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on the extension of a currently approved information collection activity related to Payment Collection Operations Contingency Plan under the ACA. According to CMS, the data collection will be used by HHS to make payments or collect charges from health insurance issuers under the

following ACA programs: advance payments of the premium tax credit, advanced cost-sharing reductions, and Marketplace (Exchange) user fees. A template will be used to make payments in January 2014 and as may be required based on HHS's operational progress.

Beginning October 1, 2013, qualified individuals and qualified employees could purchase private health insurance coverage through Exchanges (Marketplaces) for January 1, 2014 effective dates. The ACA established Affordable Insurance Exchanges (§1311(b)) to provide individuals and small business employees with access to health insurance coverage beginning January 1, 2014. Furthermore, an Exchange makes an advance determination of tax credit eligibility for individuals who enroll in a qualified health plan (QHP) through the Exchange and pursue financial assistance (§1401, 1411, and 1412). QHPs are health plans that have been certified by an Exchange, provide essential health benefits (EHB, §1301) and follow established limits on cost-sharing (such as reduced deductibles, copayments, and out-of-pocket maximum amounts).

Using information available at the time of an individual applicant's enrollment, the Exchange determines whether the individual meets income and other requirements for advance payments and the amount of the advance payments that can be used to pay premiums. Advance payments are made periodically to the issuer of the QHP in which the individual enrolls (§1412). §1402 provides for the reduction of cost sharing for certain individuals enrolled in a QHP through an Exchange and §1412 provides for the advance payment of these reductions to health insurance issuers. Moreover, the ACA directs the issuers to reduce EHB cost sharing for individuals with household incomes between 100% and 400% FPL who are enrolled in a silver level QHP through an individual market Exchange and who are eligible for advance payments of the premium tax credit.

Comments are due September 25, 2014.

Read the notice at: www.gpo.gov/fdsys/pkg/FR-2014-08-26/pdf/2014-20255.pdf (see item #4)

8/25/14 HHS/CMS issued a notice under the Paperwork Reduction Act of 1995 (PRA) seeking comments on the revision of a currently approved information collection activity related to the Reporting Requirements for Grants to States for Rate Review Cycle I, Cycle II, Cycle III, and Cycle IV and Effective Rate Review Programs. According to CMS, the notice explains that the Rate Review Grant Program is required to assist states in the establishment of "Data Centers" that gather, evaluate, and publicize health care pricing data for the public.

Along with this information collection request, HHS announced the Cycle IV of the Rate Review Grant opportunity, "Grants to States to Support Health Insurance Rate Review and Increase Transparency in the Pricing of Medical Services." As indicated by HHS/CMS, the purpose of Cycle IV of the Rate Review Grant Program is not only to continue the rate review successes of Cycles I- III but also and to offer enhanced support to the aforementioned Data Centers.

States and territories that are awarded funds under the Cycle IV funding opportunity are required to provide the HHS Secretary with rate review data, four quarterly reports, one annual report per year until the end of the grant period (as well as a final report) describing the state's development towards a more comprehensive and effective rate review process.

The rate review program under §1003 requires that insurers seeking rate increases of 10% or more for non-grandfathered plans in the individual and small group markets publicly and clearly disclose the proposed increases and the justification for them. Such increases are reviewed by either state or federal experts (in states that do not have a rate review program deemed effective by HHS) to determine whether they are unreasonable. Although the ACA does not grant HHS the authority to block a proposed rate increase, companies whose rates have been determined unreasonable must either reduce their rate hikes or post a justification on their website within 10 days of the rate review determination. CMS determined that both the individual and small-group markets in Massachusetts meet standards under §1003 and that the Commonwealth does have an effective rate review process.

Comments are due September 24, 2014.

Read the notice at: www.gpo.gov/fdsys/pkg/FR-2014-08-25/pdf/2014-20041.pdf (see item #2)

8/22/14 HHS/Treasury/DOL issued proposed and interim final rules about employer coverage of certain preventive services (such as contraception)under ACA §1001 (2713). The interim final rule maintains the existing accommodation for certain religious non-profits that object to providing such coverage, but also create an additional pathway for eligible organizations to provide notice of their objection to covering contraceptive services. In addition, the proposed rule solicits comment how it might extend to certain "closely held" for-profit companies the same accommodation that is available to non-profit religious organizations, while continuing to urge Congress to take action to ensure women's access to contraception services.

The guidance follows the June 30, 2014 Supreme Court decision to allow closely-held for-profit corporations to use the accommodation previously outlined by HHS for companies who object to providing contraceptive services as part of the benefits under the ACA-required women's preventive services. The ruling issued earlier this summer by the Supreme Court in the *Burwell v. Hobby Lobby Stores, Inc.* case allows certain employers to withhold contraceptive care from their employees' health coverage based on their own religious beliefs.

The interim final rule allows eligible non-profit organizations to notify the HHS in writing of their religious objection to providing contraception coverage. HHS and DOL will then notify insurers and third party administrators so that enrollees in plans of such organizations receive separate coverage for contraceptive services, with no additional cost to the enrollee or the employer. The interim final rule solicits comments, but went into effect upon publication.

The proposed rulessolicit comments on how the Administration could extend to certain closely held "for-profit" entities, like Hobby Lobby, the same accommodation that is available to non-profit religious organizations. Under the proposal, such companies would not have to contract, arrange, pay or refer for contraceptive coverage to which they object on religious grounds. The proposal seeks comment on how to define a "closely held" for-profit company and whether other steps might be appropriate to implement such a policy.

On July 28, 2014 the agencies issued a final rule called "Coverage of Certain Preventive Services Under the Affordable Care Act" which implements provisions under ACA §1001(2713) that provide women with coverage for preventive care that includes all-FDA approved contraceptive services without cost sharing, while respecting the concerns of certain religious organizations, including certain non-profit religious organizations. Under the final rule non-exempt, non-grandfathered group health plans are required to provide such coverage. Group health plans of "religious employers" are exempted from the requirement to provide contraceptive coverage if they have religious objections to contraception.

Under the ACA, most health plans are required to provide women with coverage for recommended preventive care without charging a co-payment, co-insurance or a deductible. The rule ensures that such non-profit organizations with religious objections won't have to contract, arrange, pay, or refer for insurance coverage for these services to their employees.

Women's preventive health services include well-woman visits, support for breastfeeding equipment, contraception, and domestic violence screening and counseling.

Comments on the proposed rules are due October 21, 2014.

Read the proposed rules (which were published in the Federal Register on August 27, 2014) at: www.gpo.gov/fdsys/pkg/FR-2014-08-27/pdf/2014-20254.pdf

Comments on the interim final rules are due October 27, 2014.

Read the interim final rules (which were published in the Federal Register on August 27, 2014) at: www.gpo.gov/fdsys/pkg/FR-2014-08-27/pdf/2014-20252.pdf

For more information on women's preventive services coverage, visit: HHS.Gov

Prior guidance can be found at: www.hhs.gov/healthcare/index.html

News

8/26/14 The U.S. Preventive Services Task Force (USPSTF) issued a final recommendation statement on Behavioral Counseling to Promote a Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Known Risk Factors. The USPSTF recommends that overweight and obese adults who have additional cardiovascular disease (CVD) risk factors participate in intensive behavioral counseling interventions to promote a healthy diet and physical activity for CVD prevention. The USPSTF assigned a "B" rating to the recommendation, indicating that the Task Force recommends the service.

According to the USPSTF, CVD, primarily in the form of heart disease and stroke, is a leading cause of death in the United States. Adults who adhere to a healthy diet and physical activity have lower chances of cardiovascular death than those who do not. Furthermore, all individuals who follow healthy eating behaviors and increased physical activity will see benefits in their health.

The USPSTF's evidence review found that overweight or obese adults have an increased risk of CVD. Those adults who participate in intensive behavioral counseling had a moderate benefit on risk for CVD, including improvements in body mass index (BMI), blood pressure, lipids, fasting glucose, and levels of physical activity. The USPSTF found inadequate evidence that intensive behavioral counseling interventions lead to improvements in mortality or CVD rates.

However, none of the dietary intervention studies explicitly reported adverse events. Studies of physical activity interventions reported mostly minor adverse events, and intense physical activity was very rarely associated with cardiovascular events. The USPSTF found adequate evidence that the harms of behavioral counseling interventions are small to none.

The USPSTF is an independent panel of non-federal government experts that conduct reviews of scientific evidence of preventive health care services. The USPSTF then develops and publishes recommendations for primary care clinicians and health systems in the form of recommendation statements. As part of their recommendations process, the USPSTF will assign definitions to the services they review based on the certainty that a patient will receive a substantial benefit from receiving the benefit. Services that are graded "A" and "B" are highly recommended and the USPSTF believes there is a high certainty that patient will receive a substantial or moderate benefit.

Under ACA §1001, all of the recommended services receiving grades of "A" or "B" must be provided without cost-sharing when delivered by an in-network health insurance provider in the plan years (or, in the individual market, policy years) that begin on or after September 23, 2010. Because the recommendation was finalized with "B" rating, then behavioral counseling to promote a healthy diet and physical activity for cardiovascular disease prevention in adults with known risk factors will be required to be covered without cost-sharing under the ACA.

Read the final recommendation statement at:
www.uspreventiveservicestaskforce.org/uspstf13/cvdhighrisk/cvdhighriskfinalrs.htm

Learn more about preventive services covered under the ACA at: HHS.Gov

Learn more about the USPSTF at: www.uspreventiveservicestaskforce.org/

8/26/14 HHS announced that approximately $35.7 million in HRSA Funded Health Center Program grants were awarded to 147 community health centers in 44 states, the District of Columbia, and Puerto Rico. The awards will be used to support patient-centered medical homes through new construction and facility renovations.According to HHS, the patient-centered medical home delivery model is designed to improve quality of care through team-based coordination of care and empowering the patient to be a partner in their own care.

The grant awardees included the following three health centers in Massachusetts: Greater New Bedford

Community Health Center, Inc., New Bedford; Lowell Community Health Center, Inc., Lowell; and Outer Cape Health Services, Wellfleet.

There are currently 36 health centers in Massachusetts participating in the HRSA Funded Health Center Program.

For more information about HRSA Funded Health Centers, visit: HRSA.GOV

To read the announcement, visit: www.hhs.gov/news/press/2014pres/08/20140826a.html

July 2014 The Medicaid and CHIP Payment and Access Commission (MACPAC) released its July 2014 "MAC Facts" report, *Revisiting Emergency Department Use in Medicaid*. According to MACPAC's findings, a majority of emergency room visits by Medicaid beneficiaries are for urgent symptoms that require rapid medical attention, while non-urgent visits to the emergency room constitute 10% of Medicaid-covered emergency department visits.

In addition to explaining that it is a common myth that much of the emergency department use among Medicaid enrollees is unnecessary, the report states that, despite the fact that nearly all Medicaid enrollees report having a usual place of care other than the emergency department, approximately 1/3 of adult and 13% of child enrollees have reported barriers to finding a doctor or delays in getting needed care.

In the report, MACPAC explains that higher emergency department use among Medicaid enrollees compared to privately insured and uninsured individuals can also be attributed to the higher rates and more severe cases of chronic disease and disability experienced relative to those who are privately insured. The level of emergency department utilization can also be indicative of poor access to primary, specialty, dental, and outpatient mental health care in other settings. MACPAC recommends expanding the availability of primary care and changing health care delivery systems as a way to more efficient usage of the emergency department.

MACPAC was established by the Children's Health Insurance Program Reauthorization Act and later expanded and funded through ACA §2801 and §10607. The commission consists of experts, government officials, executives and medical professionals. MACPAC is tasked with reviewing state and federal Medicaid and CHIP access and payment policies and making recommendations to Congress, the HHS Secretary, and the states on a wide range of issues affecting Medicaid and CHIP populations, including the implementation of health care reform.

Read the report at: www.macpac.gov/publications/MACFacts-EDuse_2014-07.pdf?attredirects=0

Upcoming Events

Massachusetts Health Homes Initiative Public Forum
September 5, 2014
10:00 AM - 12:00 PM
Saxe Room
Worcester Public Library
3 Salem St, Worcester, MA 01608

Please R.S.V.P. to Donna Kymalainen at Donna.Kymalainen@state.ma.us.

Reasonable accommodations are available upon request. Please contact Donna Kymalainen at Donna.Kymalainen@state.ma.us to request accommodations.

Agenda
- Populations to be served
- Health Home Provider Types
- Addressing Overlap Issues with other MassHealth and DMH Programs

- Payment Model
- Steps to Submission of SPA
- Implementation of Program

Integrating Medicare and Medicaid for Dual Eligible Individuals (also known as One Care) Implementation Council Meeting

Friday, September 12, 2014 1:00 PM - 3:00 PM
State Transportation Building
10 Park Plaza
Boston, MA

A meeting agenda and any meeting material will be distributed prior to the meetings.

Meetings of the Implementation Council are open to stakeholders and members of the public with an interest in One Care. Reasonable accommodations are available upon request. Please contact Donna Kymalainen at Donna.Kymalainen@umassmed.edu to request accommodations.

Bookmark the **Massachusetts National Health Care Reform website** at:
National Health Care Reform to read updates on ACA implementation in Massachusetts.

Remember to check the Mass.Gov website at: Dual Eligibles for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.

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